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HEALTH CARE SAFETY NET ACT OF 2007

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Mr. KENNEDY, from the Committee on Health, Education, Labor, and Pensions, submitted the following

R E P O R T

[To accompany S. 901]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 901) to amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and an amendment to the title and recommends that the bill (as amended) do pass.

CONTENTS

I. PURPOSE AND NEED FOR LEGISLATION

The Health Care Safety Net Act of 2007 reauthorizes and strengthens three programs which together provide a safety net that helps millions of Americans each year access needed health care services. In doing so, the committee is acting to maintain, improve, and increase its support for these programs, which enable safety net providers located in rural and urban areas throughout this country to offer health care services to millions of underserved and uninsured people. The programs included in this act are:

69–010

• The Health Centers program, established under Title III, Section 330 of the Public Health Service Act; supports the provision of health care and related services to the medically underserved—meaning those individuals living in rural or urban communities that are federally-designated as medically underserved, or whose populations are members of a federally-designated medically underserved population.

• The National Health Service Corps, authorized under Title III, Sections 331 through 338L of the Public Health Service Act; assists in the delivery of health services in health professional shortage areas by providing access to scholarships and loan repayments to eligible clinicians.

• Rural Health Programs, located in Title III, Sections 330A, 330I, 330J, and 330K of the Public Health Service Act; assist with the provision of coordinated care in rural areas. These programs include the Rural Health Care Services Outreach, Rural Health Network Development, Small Health Care Provider Quality Improvement, Telehealth Network, Telehealth Resource Centers, Rural Emergency Medical Service Training and Equipment Assistance, and Mental Health Service Delivered Via Telehealth.

THE HEALTH CENTERS PROGRAM

Introduction

The Committee has a long history of supporting the work of safety net providers in urban and rural areas who dedicate their efforts to providing care for those individuals who would otherwise not have access to a regular source of health care. At a time when 47 million Americans are without health insurance and over 56 million lack adequate access to a primary care physician due to an actual physician shortage in their communities, existing safety net providers continue to grapple with increasing demands for care from the uninsured and underinsured populations in this country. Thousands of communities across the country today continue to experience shortages of accessible, cost-effective, preventive and primary health care services especially for individuals who are unable to pay for such care.

History of Health Centers Program

In response to the large number of individuals living in medically underserved areas, as well as the growing number of special populations lacking access to preventive and primary health care services, in 1965, Congress created the Health Centers program, formally authorizing it in 1975. For more than 40 years, the Health Centers program has effectively and efficiently assured access to cost-effective, high quality, preventive and primary care services, thereby improving the health status of the Nation's underserved and vulnerable populations. This program was designed to empower communities to address local health access challenges and to improve the health status of their underserved and vulnerable populations. Health centers do this by building community-based primary care capacity and by offering case management, home visitation, outreach, and other enabling services to increase utilization by vulnerable populations and improve the effectiveness of the preventive and primary care they offer. Health centers serve as a pro-

totype for effective public-private partnerships, demonstrating their ability to meet pressing local health needs while being held accountable for meeting national performance standards. The care provided at health centers contributes to success of the program in reducing avoidable hospitalizations, lowering emergency room use, and lessening the need for specialty care, thus saving billions for taxpayers and society.[1]

Core requirements of the Health Centers Program

The Health Centers program's core elements found in Section 330 of the Public Health Service Act, as established by Congress, and last reauthorized in 2002 as part of the Health Care Safety Net Amendments Act, Public Law (P.L.) 107–251 stipulate that each Federally-supported health center must:

1. Be located in, and serve, a community that is federally-designated as "medically underserved," thus ensuring the proper targeting of Federal resources to areas of greatest need;
2. Make its services available to all residents of the community, without regard for ability (or inability) to pay for such services, and make those services affordable by discounting the health center's charges in accordance with family income for otherwise uncompensated care provided to low-income families;
3. Provide comprehensive primary health care services, including preventive care (such as regular check-ups and pap smears), care for acute and chronic illnesses and injuries, services to improve both the accessibility of care (such as transportation and translation services) and the effectiveness of care (such as health/nutrition education), and patient case management;
4. Be governed by a board of directors, a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the health care needs of the community it serves.

Health centers must also meet strict operational, clinical and financial standards, as well as reporting and performance requirements.

Types of health centers

During the 1996 reauthorization of the Health Centers program (Health Centers Consolidation Act of 1996, P.L. 104–299), the committee consolidated four separately targeted health center authorities under a single authority, while maintaining distinct resources to serve vulnerable subpopulations of migrant and seasonal farm workers and their families, homeless individuals, and residents of public housing. The program currently serves over 17 million medi-

[1] National Association of Community Health Centers and The Robert Graham Center. Access Denied: A Look at America's Medically Disenfranchised. March 2007. *www.nachc.com/research-data.cfm.* NACHC and Association of Community Affiliated Plans, The Impact of Health Centers and Community-Affiliated Health Plans on Emergency Department Use, April 2007. *www.nachc.com/research-data.cfm.* National Association of Community Health Centers, The Robert Graham Center, and Capital Link. Access Granted: The Primary Care Payoff. August 2007. *www.nachc.com/research-reports.cfm.*

cally underserved people in more than 6,300 service delivery sites in every State and territory.[2]

1. Community Health Centers—Community Health Centers were first funded by Congress in the mid–1960s as neighborhood health centers. By the early 1970s, approximately 100 neighborhood health centers had been established under the Economic Opportunity Act. These centers were designed to provide accessible, personal health services to low-income families. Community and consumer participation in the organization and ongoing governance of the centers remain central elements of the program. Each center is required to have a governing board, a majority of whose members are comprised of consumers of the center's services.

With the phase-out of the Office of Economic Opportunity in the early 1970s, the centers supported under this authority were transferred to the Public Health Service Act. While services were directed to the poor and near poor, the centers also provided access to a broader population who could pay all or part of the cost of their health care. The Community Health Center program, as authorized under Section 330 of the Public Health Service Act, was established in 1975 by Public Law (P.L.) 94–63.

2. Migrant Health Center—The Migrant Health Center program was established by Congress in 1962 under the Migrant Health Act, P.L. 87–692, and was reauthorized in 1975 by P.L. 94–63. Migrant Health Centers were created to provide a broad array of medical and support services to farmworkers and their families. In addition to primary and preventive health care, many of these centers provide transportation, translation, outreach, dental, pharmacy, and environmental health services. In 2002, P.L. 107–251 clarified the eligibility of certain farmworkers to receive health center services at section 330-funded health centers. The 2002 reauthorization also called for the Department of Health and Human Services to conduct a study of the barriers to enrollment in and the possible solutions to the challenges faced by farmworkers under Medicaid and the State Children's Health Insurance Program. In 2006, a network of 140 migrant health centers provided services to over 800,000 migrant and seasonal farmworkers and their families in more than 1,052 delivery sites.[3]

3. Health Care for the Homeless—The Health Care for the Homeless program was established by Congress to provide comprehensive, high quality, case-managed, preventive and primary health care services, including substance abuse services and mental health referrals, for homeless individuals at locations accessible to them. With the enactment of P.L. 107–251, Congress clarified the eligibility of homeless youth and formerly homeless persons to receive section 330-funded services during the first 12 months following their transition to permanent housing, in order to ensure that the program remained appropriately targeted to the most vulnerable populations.

The Health Care for the Homeless program has played (and continues to play) a pivotal role in stimulating local collaboration and

[2] NACHC, 2008 based on Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System (UDS). It includes patients of federally-funded health centers, non-federally funded health centers (health center "look-alikes"), and expected patient growth for 2007–2008.

[3] NACHC, 2008 based on Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System (UDS).

coordination of health and social services. A total of 184 organizations, including community health centers, public health departments, and other community-based health service providers, currently provide care to approximately 828,000 sick and underserved homeless people annually.

4. Health Services for Residents of Public Housing—The Health Services for Residents of Public Housing program was established by Congress under the Disadvantaged Minority Health Improvement Act of 1990. This legislation focused on the disparity in health status of minority populations and placed emphasis on the development of comprehensive delivery models that address the special health problems which affect families residing in public housing complexes—especially targeting pregnant women and children. Services are provided at public housing complexes or at sites either adjacent to or immediately accessible to these complexes. In 2006, 37 organizations received funding under the program, and provided comprehensive, high quality, case-managed, family-based preventive and primary health care services to approximately 70,000 public housing residents.

Expansion of Health Centers Program

In 2000, Congress launched a historic plan—the Resolution to Expand Access to Community Health Centers (REACH) Initiative—which pledged to double access to community health centers in medically underserved areas over 5 years. With this initiative came an unprecedented $150 million increase in Federal funding for health centers, and the Health Centers program entered into a period of unparalleled growth. In 2001, the Bush administration joined this historic initiative, pledging to continue to expand the capacity of health centers to provide care.[4]

Wide bipartisan support in Congress has supported these goals and has ensured the necessary funding increases to expand the program, while supporting the infrastructure of existing centers. At the start of the President's Expansion Initiative in 2001, 10 million patients were served by the Health Centers Program. By 2006, new and expanded access points created access to care for more than 16 million people who were served at 6,000 service delivery sites in every State and territory. Additionally, support from the President and Congress have allowed several existing health centers to expand the services they offer beyond primary medical and preventive care. Service expansions have assisted health centers in providing mental health, dental, pharmaceutical and optometric services.

Success of the Health Centers Program

Since the reauthorization in 2002, the Health Centers program has continued to develop and implement a significant number of highly successful, innovative, preventive, and primary health care delivery approaches in our Nation's most needy inner cities and rural areas.

Health centers are effective in increasing access to health care services in needy communities. In 2006, more than 16 million patients were served at health centers—representing a 32.7 percent

[4] Administration FY 2001 Budget Overview.

increase over the 11.3 million persons served in 2002. Of those 16 million patients, over 6 million patients or 40 percent of all health center patients were uninsured—a 34 percent increase over the 4.4 million uninsured individuals served by centers in 2002. Further, in 2006, 23.3 percent of those uninsured individuals were children. Three million health center patients are enrollees in managed care systems. Health centers serve 1 in 7 uninsured persons, 1 in 9 Medicaid beneficiaries, and 1 in 4 low-income individuals in the United States today.[5]

Furthermore, health centers are effective at improving health outcomes, increasing access to preventive services, improving the management of chronic diseases, mitigating health disparities, and reducing avoidable hospitalizations.[6] The rates of infants born at low birth weights are lower at health centers than nationally, even though health center patients are more at risk. Women of low socio-economic status seeking care at health centers experience lower rates of low birth weight compared to all low-social economic status mothers (7.5 percent vs. 8.2 percent).[7] This trend holds for each racial/ethnic group, which is particularly noteworthy for African-American women who are especially at higher risk for adverse pregnancy outcomes. Given that two-thirds of health center patients belong to a minority group with an increased risk for low birth weight infants, this particular statistic demonstrates the competent care that health centers provide.

According to a 2002 Health Resources and Services Administration (HRSA) Community Health Center User survey, women who receive their care at health centers are more likely to receive a pap test than if they were to receive care elsewhere. This increased access to necessary preventive health services also is evident for women who are Hispanic and African-American. Furthermore, health centers have been shown to effectively mitigate health disparities. According to a report by the George Washington University, as health centers serve more of a State's low-income population, key State level disparities in communities of color decline.

Health centers provide care to millions of Americans suffering from chronic diseases. In 2006, Health Centers treated more than 927,000 patients with diabetes, 237,500 patients with heart disease, almost 1,461,000 patients with high blood pressure, and nearly 461,000 patients with asthma.[8] In fact, fully one quarter of all health center patient visits are related to a chronic illness.

Studies comparing health center patients and non-health center patients demonstrate that health centers provide services at a

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[5] NACHC, 2008 based on Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System (UDS).

[6] Starfield B and Shi L. "The Medical Home, Access to Care, and Insurance: A Review of Evidence." May 2004 Pediatrics 113(5):1493–8. Hadley J and Cunningham P. "Availability of Safety Net Providers and Access to Care of Uninsured Persons." October 2004 Health Services Research 39(5):1527–1546. O'Malley AS, et al. "Health Center Trends, 1994–2001: What Do They Portend for the Federal Growth Initiative?" March/April 2005 Health Affairs 24(2):465–472. Shi L. Regan J, Politzer RM, Luo J. "Community Health Centers and Racial/Ethnic Disparities in Healthy Life." 2001 International Journal of Health Services 31(3):567–582. Forrest CB and Whelan EM "Primary care safety-net delivery sites in the United States: A comparison of community health centers, hospital outpatient departments, and physicians' offices." 2000 JAMA 284(16):2077–2083. O'Malley et al, 2005.

[7] Shi, L. Steven, G.D., Wulu, J.T., Politzer, R. M., & Xu, J. America's health centers: Reducing Racial and Ethnic Disparities in Perinatal Care and Birth Outcomes. 2004. Health Services Research, 39 (6, Part 1), 1881–1901.

[8] NACHC, 2008 based on Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System (UDS).

lower cost per ambulatory visit, while lowering the rate of hospital inpatient days, and lower total costs of care (including decreased inpatient care costs).[9] Recently, the Health Centers program was recognized by the Office of Management and Budget as one of the most effective and efficiently run programs in the Department of Health and Human Services.

As testament to health centers' ongoing commitment to the delivery of high-quality health services, nearly 85 percent of health centers have participated in one or more of HRSA's Health Disparities Collaboratives, initiatives which focus on improving health outcomes for chronic conditions among medically-vulnerable populations, particularly minorities. The Collaboratives are designed to enhance the skills of clinical staff, strengthen the process of care through the development of extensive patient registries that improve clinicians' ability to monitor and manage the health of individual patients, and effectively educate patients on self-management of their conditions. Health center patients with chronic disease are enrolled in electronic registries for diabetes, cardiovascular disease, asthma, depression, prevention, cancer, and HIV. Eventually, every health center may be participating in at least one Collaborative.[10]

A study of 19 Midwestern health centers participating in the Diabetes Collaboratives demonstrated improved measures of diabetes-related health outcomes and quality (e.g., HbA1c measurement, eye examination referral, foot examination, and lipid assessment). The authors concluded that in just 1 year, the model employed by the Collaboratives improved diabetes care at the health centers.[11] As a result of the success of the Collaboratives, the Institute of Medicine (IOM) commended health centers for providing chronic care management that is "at least as good as, and in many cases superior to, the overall health system in terms of better quality and lower costs," and recommended health centers as models for reforming the delivery of primary health care.[12] The General Ac-

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[9] McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University. *www.mpca.net.* Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January–March 2006 Journal of Ambulatory Care Management 29(1):24–35.

Garg A, Probst JC, Sease T, Samuels ME. "Potentially Preventable Care: Ambulatory Care-Sensitive Pediatric Hospitalizations in South Carolina in 1998." September 2003 Southern Medical Journal 96(9):850–8. Epstein AJ. "The Role of Public Clinics in Preventable Hospitalizations among Vulnerable Populations." 2001 Health Services Research 32(2):405–420.

Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 Medical Care 39(6):551–56. Stuart ME, et al. Improving Medicaid Pediatric Care. Spring 1995 Journal of Public Health Management Practice 1(2):31–38.

Starfield B, et al. Costs vs. Quality in Different Types of Primary Care Settings, 28 December 1994 Journal of the American Medical Association 272(24):1903–1908.

Duggar BC, et al. Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers. Center for Health Policy Studies, 1994.

Duggar BC, et al. Health Services Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers. Center for Health Policy Studies, 1994.

Braddock D, et al. Using Medicaid Fee-For-Service Data to Develop Health Center Policy. Washington Association of Community Health Centers and Group Health Cooperative of Puget Sound, 1994.

[10] Chin MH, et al. "Improving Diabetes Care in Midwest Community Health Centers With the Health Disparities Collaborative." January 2004 Diabetes Care 27(1):2–8.

[11] Chin MH, et al. "Improving Diabetes Care in Midwest Community Health Centers With the Health Disparities Collaborative." January 2004 Diabetes Care 27(1):2–8.

[12] Institute of Medicine (IOM). Coverage Matters: Insurance and Health Care. National Academy of Sciences Press, 2001.

countability Office (GAO) has recently recognized the Collaboratives as a promising Federal program targeting health disparities that should be expanded.

The committee recognizes that the Health Centers program has been successful because of the ability of the centers to offer integrated, high quality, prevention-oriented, case-managed, and family-focused primary and preventive care services that result in appropriate and cost-effective use of ambulatory, specialty, and inpatient services by other providers. Health centers offer primary care for people of all life cycles, and a range of health and other social services is available on-site or through referrals.

This broad range of services includes health promotion, disease prevention, screening, educational, outreach, and case management services—services that are often missing from the traditional delivery of medical care, but which are particularly needed by high-risk populations with multiple health problems and facing significant barriers to access to care. Congress broadened this range of health center services in P.L. 107–251 by increasing the types of additional health services for which grant funding may be provided with the inclusion of behavioral and mental health services, public health services, and recuperative care services as optional services that health centers can choose to provide. Additionally, the 2002 reauthorization revised the definition of "environmental health services" to permit health centers to offer the detection and alleviation of chemical and pesticide exposures, the promotion of indoor and outdoor air quality, and the detection and remediation of lead exposures.

More than 11,887 primary care physicians, nurse practitioners, physician assistants, and certified nurse midwives create the core clinical staff of health centers nationally. Further, health centers are home to 2,626 dentists and hygienists, as well as 1,559 psychiatrists and other mental health providers. Health centers also have been assisted greatly in attracting and retaining quality providers through the National Health Service Corps. Health centers have also been actively involved with academic medical centers in providing community-based training of physicians, nurses, and other health professionals.

In addition, the Health Center program has enabled underserved communities to design and develop their own local solutions to their problems of medical underservice. By supporting the development and operation of health centers at the community level, the health centers program has assured that centers are community-responsive and accessible. Community members and patients play an active role in centers' decisionmaking and planning. By working with local communities and State organizations to plan, develop, and determine priorities for the allocation of resources, the Health Center program has successfully funded new and expanded programs and services in those communities that are most in need. Community Health Centers attract private-pay and privately insured individuals and families, in addition to individuals who are uninsured or covered by Medicaid.

Several studies over the years have reported favorably on the quality and cost-effectiveness of the care offered by health centers. These studies cite evidence of health centers' clinical quality and patient satisfaction measures which compared favorably to national

standards.[13] Studies demonstrate that patients in underserved areas served by health centers had 5.8 fewer hospitalizations per 1,000 people over 3 years than those in areas not served by health centers. According to the National Association of Community Health Centers, medical expenses for health center patients are 41 percent lower compared to patients seen elsewhere. As a result, they save the health care system between $9.9 and $17.6 billion a year.[14]

Continued need for health centers

While the Health Centers Program has made historic gains in providing increased access to and availability of health care services in medically-underserved communities and populations, major challenges still persist. Lack of access to affordable and readily available primary and preventive care remains a pervasive problem throughout the United States. Millions of Americans experience financial barriers to getting care. Today, 47 million Americans are uninsured, and that number continues to rise. At the same time that Americans are becoming uninsured in larger numbers, the amount of charity care that physicians provide has been decreasing. According to the Center for Studying Health Systems Change, the percentage of physicians providing any free or reduced cost care decreased from 76.3 percent in 1996 to 68.2 percent in 2004. Additionally, other Americans experience barriers to care due to geography or system capacity. Currently, over 62 million people live in places designated as Health Professions Shortage Areas,[15] and 56 million Americans are considered "medically disenfranchised" because they live in areas with insufficient numbers of primary care physicians.[16] Other Americans face transportation, cultural or language barriers to care, and racial, and ethnic, and geographic disparities in access to and quality of care continue.

Despite the success of the President's expansion program, only 6 million uninsured people are reached by health centers, accounting for only 13 percent of the Nation's uninsured. Fewer than half of all approvable applications for new or expanded health center sites received funding from 2002–2006, demonstrating a demand for continued expansion. Many underserved communities continue to lack adequate resources to submit a competitive application, and in some cases to even coordinate and complete the current application. For these reasons, the committee authorized significant funding increases for this important program.

Health Centers Programs in a changing health care environment

Health centers have done an excellent job of adapting to the changing health care environment. In 1996, the committee permitted the use of grant funds to support the establishment of managed care networks and plans. Health centers across the country have taken steps to form networks with other local providers and

[13] Shin P, Markus A, and Rosenbaum S. Measuring Health Centers against Standard Indicators of High Quality Performance: Early Results from a Multi-Site Demonstration Project. Interim Report. Prepared for the United Health Foundation, August 2006. www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/United_Health_Foundation_report_082106.pdf.

[14] NACHC, 2008 *"Access Granted: The Primary Care Payoff"*.

[15] HRSA, data as of September 30, 2007.

[16] National Association of Community Health Centers and The Robert Graham Center. Access Denied: A Look at America's Medically Disenfranchised. March 2007. *www.nachc.com/research-data.cfm.*

develop the financial, legal, and business acumen necessary to function effectively in managed care. Almost three-fourths of all health centers are participating in managed care as subcontracting providers to managed care plans—serving 3 million managed care enrollees.

As the market continues to change, health centers are joining with each other and with other local providers to form integrated service delivery networks to coordinate and improve their purchasing power and/or to better organize the continuum of care, especially for uninsured populations. Through networks, health centers are able to leverage their talents and resources to improve health outcomes, cut administrative costs, reduce health disparities, and employ health information technology and electronic medical records. These networks include practice management networks designed to improve quality through shared expertise (such as centralized pharmaceutical or laboratory services, clinical outcomes management, or joint management/administrative services); to lower costs through shared services (such as unified financial or management information systems, or joint purchasing of services or supplies); to improve access and availability of health care services provided by the health centers participating in the network; and/or to improve the health status of communities by establishing community-based programs such as vaccine and wellness initiatives.

Today, nearly 200 health centers are involved in approximately 20 local and regional operational networks across a majority of States, each designed to lower costs and improve care. In the 2002 Health Care Safety Net Amendments, Congress authorized the use of up to 2 percent of Section 330 appropriations for the funding of health center networks.

Since the last reauthorization of the Health Centers program, Health Information Technology (HIT) has emerged as a valuable resource for all health care providers. In order to better coordinate care and improve patient outcomes and quality, health care providers and medical institutions throughout the health system have adopted HIT and Electronic Medical Records (EMR). Use of HIT and EMR reduces medical errors, allows for greater coordination of care, improves the quality of care delivered, and saves money at the individual and systemic level. While a majority of health centers (60 percent) plan on implementing an Electronic Health Records (EHR) system in the near future, currently 13 percent of health centers have a fully operational EHR system. Lack of capital resources is overwhelmingly named as the biggest obstacle to adoption. By integrating health information technology into operations, health centers will connect more effectively with the entire health care system, and can continue to lead the way toward an improved system of care.

NATIONAL HEALTH SERVICE CORPS

Introduction

The National Health Service Corps (NHSC), authorized under Title III of the Public Health Service Act, plays a critical role in providing care for medically underserved populations by placing clinicians in urban and rural communities with severe shortages of

health care providers. The NHSC is comprised of scholarship and loan repayment programs that provide education assistance to health professions students in return for a period of obligated service in a shortage area.

Background and need for Program

Nationwide, there is a shortage of primary care providers, and this problem is exacerbated in rural and certain urban areas. The availability of primary care physicians has deteriorated in recent years. In fact, the number of primary care physicians per capita has changed very little, while the number of specialists has been rapidly growing—accounting for more than three-quarters of the growth in per capita physicians from 1980 to 1999. At the same time, it is estimated that the demand for primary care providers will increase 38 percent from 2000 to 2020. The lack of primary care physicians is expected to be compounded by a rapidly rising elderly population. The number of people ages 65 and older is expected to grow 54 percent between 2000 and 2010, while the number over the age of 85 will grow 43 percent over the same time.[17] This combination of factors will lead to a growing shortage of primary care providers, estimated by the Council on Graduate Medical Education to be a shortage of at least 90,000 full time physicians by 2020.[18] Communities that are already experiencing shortages are especially likely to be hard hit. Additionally, low income individuals will bear a significant burden, because studies suggest that fewer physicians are willing to treat Medicaid and uninsured patients. Therefore, investment in the NHSC program, which helps to get providers in these medically underserved communities, is needed.

While NHSC assignees are successful in providing health care services to nearly 5 million Americans each year, there is still a great need for investment in the program. This is demonstrated by the fact that there are more qualified applicants to the NHSC program than awards available to be made. In 2006 there were approximately 1,800 applicants to the program, but only sufficient funding to award approximately 800 awards. Additionally, the number of vacancies posted on the NHSC Job Opportunity List far exceeds the number of NHSC awardees. As of October 2007, there were 4,888 vacancies posted on the Job Opportunity List, with 55 percent (2,704) of these in health centers.

History and description of program

The National Health Service Corps (NHSC) program was originally enacted by the Emergency Health Personnel Act of 1970 to respond to the geographic misdistribution of primary care health professionals. In 1972, Congress created the Scholarship programs to allow health professions students to receive support for their educational costs in return for service in a designated area. In return for each year of scholarship support they receive, students agree to provide services for 1 year, with a 2-year minimum service

[17] American College of Physicians. The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care. January 30, 2006. *http://www.acponline.org/hpp/statehc06_1.pdf*.

[18] Council on Graduate Medical Education (January 2005). Sixteenth Report: Physician Workforce Policy Guidelines for the United States, 2000–2020. *http://www.cogme.gov/16.pdf*.

obligation. In 1987, Congress enacted the NHSC Loan Repayment program, under which the Federal Government agrees to repay both governmental and commercial loan obligations incurred by health professionals for their education in exchange for service in a designated area. In that same year, Congress established a State Loan Repayment program. Under this program, if a State establishes a loan repayment program similar to the NHSC Loan Repayment program, the Department could fund up to 75 percent of the total costs through a grant to the State.

In 1990, Congress reauthorized the NHSC, extending the program for 10 years with the enactment of the National Health Service Corps Revitalization Amendments of 1990 (P.L. 101–597). In reauthorizing the NHSC, Congress made several changes to the program, including a strict prioritization of areas of greatest shortages for placement of new assignees; requirements to include individual assignees' characteristics in making placements; improved incentives for recruitment and retention of health professionals; increased utilization of nurse practitioners, physician assistants, and nurse midwives; and renaming of Health Manpower Shortage Areas (HMSAs) to Health Professions Shortage Areas (HPSAs). The NHSC was last reauthorized in 2002, and this authorization expired on September 30, 2006.

While the NHSC program has proven successful in addressing health professional shortages in many areas, funding limitations have restricted the program's ability to meet its primary goal. After reauthorization of the NHSC in 2002, funding for the program increased to $171 million in fiscal year 2003, $169.9 million in fiscal year 2004, and $131.4 million in fiscal year 2005, before returning to the fiscal year 2001 level of $125 million in fiscal year 2006 and fiscal year 2007.

According to HRSA, in 2006, 4,109 clinicians were practicing in underserved areas through the National Health Service Corps. Of these, 2,051 clinicians worked in grant supported health centers, while the remaining 2,058 clinicians worked in "free standing" sites which include rural health centers, public health departments, community mental health centers, private and group practices, Indian Health Service sites (tribal and Federal), State and Federal prisons, and Immigration and Customs Enforcement sites. NHSC funding is available to a variety of clinicians, including physicians (including psychiatrists), dentists, dental hygienists, nurse practitioners, physician assistants, nurse midwives, and mental and behavioral health professionals. Throughout its history, NHSC awards have also been made to other types of providers such as optometrists, chiropractors, and pharmacists. The committee notes that in many cases, the provision of some health care services may not have been possible without the presence of an NHSC assignee. Nevertheless, the committee also notes that partly due to a lack of adequate funding, the NHSC has a limited capacity to meet the needs of people living in primary care, mental, or dental HPSAs.

Relationship between health centers and rural health clinics and the NHSC

There is synergy between the NHSC program and the community health centers program and rural health clinics because both entities frequently utilize NHSC providers to staff their facilities. How-

ever, despite the investment already being made in placing providers in these entities, there is still a shortage of providers in these, as well as other settings. In light of the national shortage of primary care providers, the committee strongly believes that we must act to reauthorize and improve the NHSC program to help meet the need for physicians caring for underserved populations. Our increased investment in community health centers since 2001 should be matched by additional authorizations for the NHSC as well.

RURAL HEALTH CARE PROGRAMS

In section 330A(j) of the PHSA, the committee reauthorizes Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs. The programs in section 330A(j) specifically consider the diversity of rural America and have provided rural communities with flexible mechanisms of receiving Federal funds for specific health care needs. The five grant programs under this authority support collaborative models to deliver basic health care services to the 54 million Americans living in rural areas.

The Rural Health Care Services Outreach Program supports projects that demonstrate creative or effective models of outreach and service delivery in rural communities that lack essential health care services. The emphasis is on community involvement in the development and ongoing operation of the program, requiring the grantee to form a consortium with at least two additional partners. Through consortia of schools, churches, emergency medical service providers, local universities, private practitioners and the like, rural communities have managed to provide many services including hospice care, health check-ups for children and prenatal care to women in remote areas. The population served by the grants has historically been across the spectrum of care, with a majority of grants focusing on the non-Medicare population. The Department of Health and Human Services estimates these funds have brought care that would not otherwise have been available to at least 2 million rural citizens across the country. In the past 3 years, this program has funded many projects, including a grant to rural New Hampshire enabling implementation of a chronic disease management program for individuals with diabetes and congestive heart failure; a grant to rural Louisiana targeting at-risk and obese preteens; and a program in rural Kansas providing dental services targeted to children and pregnant women. The general program line includes support for grants to the eight States in the Mississippi Delta for network and rural health infrastructure development, and a cooperative agreement supporting targeted activities focusing on frontier extended stay clinics.

The Small Health Care Provider Quality Improvement provision, a subset of the Rural Health Outreach Grant Program, was added to this authority when the program was re-authorized by the Safety Net Amendments of 2002. The programs were initially funded in 2006. These grants help small health care providers focus on specific interventions to improve health care quality in specific chronic disease areas. Fifteen grants were awarded in fiscal year 2007 with a focus on diabetes, and there are plans for up to 60 grants in fiscal year 2008 targeting cardiovascular disease. These

grant programs provide an opportunity for grantees to improve quality and enhance small rural health care providers in delivering care to rural communities.

The Rural Health Network Development grant program allows grants to fund the integration of health services provided by rural communities. This integration helps to overcome the fragmentation of health care services in rural areas, improves the coordination of those services, and achieves economies of scale. The grants focus on integrating clinical, information, administrative and financial systems across members. This integration enables rural communities to strengthen the infrastructure of health delivery.

In authorizing the continuation of these programs, the committee recognizes the great importance of these flexible grants in enabling smaller, rural communities to provide health services to a population of about 3.2 million that is frequently underserved, have higher rates of poverty and unemployment, are older, and have a poorer health status.

II. SUMMARY

The purpose of the Health Care Safety Net Act of 2007 is to amend the Public Health Service Act to provide additional authorizations of appropriations for fiscal year 2008 through fiscal year 2012 for Health Centers, the National Health Service Corps, and Rural Health Programs, to meet the health care needs of medically underserved populations.

COMMUNITY HEALTH CENTERS

The legislation increases authorization levels for the health centers program, and also authorizes several studies including:

1. A school based health center study conducted by the Comptroller General of the United States.
2. A health care quality study conducted by the Agency for Healthcare Research and Quality.
3. A study on an integrated health systems model for the delivery of care to medically underserved population conducted by the Comptroller General of the United States.

NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps is amended by increasing the authorization levels for fiscal year 2008 through fiscal year 2012. Additionally, the bill strikes language that placed a 6-year time limit on automatic Health Professional Shortage Area (HPSA) facility designations that were extended to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The NHSC is also amended to provide increased emphasis on professional development and training for Corps members.

RURAL HEALTHCARE PROGRAMS

The authorization level for rural health care programs is increased to $45 million for fiscal years 2008 through 2012.

III. HISTORY OF LEGISLATION AND VOTES IN COMMITTEE

The Community Health Centers, National Health Service Corps, and rural health programs were last reauthorized in the 107th

Congress with the Health Care Safety Net Amendments of 2001 (S. 1533). This bill was passed by the House and Senate, and became Public Law No. 107–251 on October 26, 2002.

During the 109th Congress, Senator Hatch and 63 cosponsors introduced, S. 3771, The Health Centers Renewal Act of 2006. This bill amended the Public Health Service Act to include increased authorization of appropriations for the Community Health Centers program. The bill was read twice and referred to the committee. On September 20, 2006, the committee ordered the bill to be reported without amendment favorably to the full Senate. On September 25, 2006, Senator Enzi reported the bill with an amendment in the nature of a substitute, without written report. The bill was placed on the Senate Legislative Calendar under General Orders (Calendar no. 638). No further action was taken on this bill during the 109th Congress.

The bill was reintroduced in the 110th Congress as S. 901, the Health Centers Renewal Act of 2007 by Senator Kennedy on March 15, 2007. The bill, which had 17 original cosponsors, and 68 total cosponsors, amended the Public Health Service Act to include increased authorization of appropriations for the Community Health Centers program for fiscal years 2008 through 2012. The bill was combined with S. 941 introduced by Senator Sanders. On November 14, 2007 the committee considered and unanimously approved a manager's amendment to S. 901, and the committee approved the bill, as amended, by voice vote. The bill was placed on the Senate Legislative Calendar under General Orders (Calendar no. 548) on December 18, 2007.

IV. Explanation of Bill and Committee Views

The committee recognizes that the health centers, NHSC, and rural grants programs have made a significant contribution to the health of medically needy populations. The committee bill reauthorizes the programs, and increases the authorization levels for 5 years, beginning in fiscal year 2008.

COMMUNITY HEALTH CENTERS

Explanation of bill

The legislation increases the authorization levels for the community health centers program as follows:

$2,213,020,000 in fiscal year 2008;
$2,451,394,400 in fiscal year 2009;
$2,757,818,700 in fiscal year 2010;
$3,116,335,131 in fiscal year 2011; and
$3,537,040,374 in fiscal year 2012.

Additionally, the legislation authorizes several studies as follows:

1. A study on school-based health centers to be conducted by the Comptroller General of the United States. The study would determine the impact of Federal funding on the operation of school-based health centers, costs savings to other programs, the impact on the Federal budget and the health of students by providing funds, and the impact of access to health care from school-based health centers in rural or underserved areas.

2. A health care quality study to be conducted by HRSA. HRSA would produce a report that describes the agency's efforts to ex-

pand and accelerate quality improvement activities in health centers.

3. A study on the integrated health systems model for the delivery of health care services to medically underserved populations. The GAO shall conduct a study on integrated health systems models at not more than 10 sites.

Forty-seven million Americans continue to lack health insurance and the number of uninsured continues to rise. Many private, nonprofit safety net providers have a historical mission of serving the poor and vulnerable and many of these providers established neighborhood clinics as a way to improve access to primary and preventive care, and to offer the uninsured a cost-effective alternative to the hospital emergency room for their primary care needs. In this study, the Comptroller General of the United States would be required to report back to Congress on the role of integrated health care systems in providing access to primary and preventive care to the medically underserved, as well as access to specialty and hospital care. For purposes of this study, an integrated health system is defined as a private nonprofit health system that has a demonstrated capacity and commitment to provide a full range of primary, specialty, and hospital care in both inpatient and outpatient settings and is organized to provide such care in a coordinated fashion. The Comptroller General should include in its report any economies of scale that are beneficial to a clinic because of its affiliation with a parent provider, current sources of its funding, patient mix based on income and insurance status, payer reimbursement rates in comparison to other providers, the number of patients served by the clinic, and whether these clinics improve specialty and hospital access for poor and vulnerable populations.

Such study shall include an assessment of providers in a wide variety of settings, including inner city, frontier areas, and a major rural teaching hospital defined as a hospital that is located in a rural area (as defined in Section 1886(d)(2)(D) of the Social Security Act) that is engaged in approved graduate medical education residency programs in medicine, osteopathy, dentistry, or podiatry, and sponsors accredited residency and fellowship programs, including active programs in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, and psychiatry. One nurse managed health clinic should also be included and would be defined as an integrated health system for purposes of this study (the term "nurse-managed health clinic" means nurse-practice arrangement, managed by advanced practice nurses, that provides care for underserved and vulnerable populations and is associated with a school, college or department of nursing and/or an independent non-profit health or social services agency). Finally, clinics operated by large non-profit organizations with a historical commitment to providing primary and preventive care for the medically underserved should also be included.

Committee views

Importance of health centers' base grant adjustments

Considerable investment in new community health centers and in expansion of services at existing CHCs has occurred during the past 5 years with strong leadership by the Executive and Congres-

sional branches of the government. The committee supports the addition of new health centers and expansion of existing ones, and supports consideration of base grant adjustments for health centers that meet Program Expectation guidelines. Most CHCs operate on narrow margins, and there are ongoing requirements to keep up with rising costs for providers, facilities, technology, and energy in order to sustain current service levels. Health centers also face increasing numbers of uninsured and under-insured individuals as employer-based insurance shrinks. The committee notes that Congress has routinely allocated annual increased funding for existing centers to offset the rising cost of health care and to meet the demands for care for the uninsured populations served by the centers. The committee encourages HRSA to develop criteria and allocate funding that will allow health centers to receive an annual grant adjustment that adequately addresses rising costs, growing patient populations, and other pressing concerns as they arise.

Value and importance of expanded technical assistance

The committee believes that the health centers program has been successful in large part because of attention to continuous quality improvement to all facets of health center operations. The committee recognizes the valuable information, training and technical assistance activities performed by national, State and regional organizations that represent the recipients of service grants under the health centers program. These organizations have provided a full range of tools for health center staff, including training programs regarding financial management, clinical practice guidelines, regulatory and legal requirements, board governance, corporate compliance, program planning and proposal writing, and strategic business planning. In order to ensure the sustained and successful operation and expansion of the health centers program, the committee expects the collaborative technical assistance program, and the funding provided in support of it, to be continued and expanded.

Proportional funding allocation

The committee continues the statutory funding allocation requirement for the Community Health, Migrant, Homeless, and Public Housing sub authorities under section 330. The committee restored this funding allocation requirement in P.L. 107–251, enacted in 2002. The committee notes that when the four separate health center programs were consolidated under a single section 330 authority in 1996, the law included a requirement for allocating funds appropriated under section 330 for each of the sub authorities in accordance with the proportion of total funding they each received in Fiscal Year 1996. The committee recognizes that despite the expiration of this statutory funding allocation requirement in 1998, the Secretary has continued to adhere to the proportional allocation methodology in distributing overall health centers program funding among the four health center programs sub authorities, thus enabling health center programs to provide needed services to vulnerable, hard to reach "special populations" such as homeless individuals, residents of public housing projects, and migrant and seasonal farmworkers. These programs should be continued and expanded in accordance with the funding allocation meth-

odology in the statute. The committee commends the Secretary for continuing to allocate the same percentage each fiscal year as was allocated the previous years. The committee encourages HRSA to expand and enhance the provision of technical assistance to promote high quality applications for funding to serve special populations as well as sparsely populated communities.

Importance of health center owned and controlled networks

Health centers currently collaborate with each other and with other community providers, in many different forms of networks and partnerships designed to improve operational quality, efficiency, and effectiveness. These collaborations include managed care, integrated service, and practice management networks, which are designed to improve quality of care through shared expertise (such as shared electronic medical records systems, centralized pharmaceutical or laboratory services, clinical outcomes management, and/or joint management/ administrative services), to lower costs through shared services (such as unified financial or Management Information systems, or joint purchasing of services or supplies), or to improve access and availability of health care services. Today, nearly 200 health centers are involved in approximately 20 local and regional operational networks across a majority of States, each designed to lower costs and improve care. These networks have played a central role in the adoption, integration and maintenance of Health Information Technology (HIT), including Electronic Health Records (EHR) at and among health centers nationwide. Most of these networks, once developed, need ongoing operational support to continue and further enhance their benefits. The committee supports the continued use of these public-private partnerships to assist with the provision of health care services, and encourages the Secretary to continue allocating a portion of an increase in appropriated funds towards this purpose.

Expanding access through the Health Centers program

The committee supports continued efforts to expand the Health Centers program into medically underserved communities and populations with high poverty and no current access to a health center. The committee commends States that have made commitments to expanding access to Community Health Centers to all underserved areas throughout their States, and believes that these States should be given serious consideration when expansion opportunities are made available.

NATIONAL HEALTH SERVICE CORPS

The committee recognizes the importance of reauthorizing the National Health Service Corps program to demonstrate our commitment to addressing the need to locate providers in medically underserved areas. The legislation increases the authorization level for the NHSC program as follows:

$131,500,000 in fiscal year 2008;
$143,335,000 in fiscal year 2009;
$156,235,150 in fiscal year 2010;
$170,296,310 in fiscal year 2011; and
$185,622,980 in fiscal year 2012.

Automatic HPSA designation for community health centers and rural health clinics

The committee revised the NHSC placement criteria during the last reauthorization in 2002. The amended statute extended Automatic HPSA facility status to health centers and rural health clinics, thus making them eligible for placement of NHSC personnel, in order to reduce bureaucratic barriers to allow coordinated use of Federal resources in meeting the health care needs of areas that lack sufficient providers and services. That action recognized that the NHSC, health centers, and rural health clinics programs are intended to address similar goals: to meet the primary care needs of underserved populations.

The committee is striking language that placed a 6-year time limit on automatic Health Professional Shortage Area (HPSA) facility designations that were extended to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). It is the committee's intent that FQHCs and RHCs automatic HPSA designation continue. The committee notes that all FQHCs must by law be located in medically underserved areas as determined by the Secretary, and that both FQHCs and RHCs must compete with all applicants to obtain NHSC placements. Therefore, the committee has concluded that the 6-year limit is unnecessary. The committee also notes concern about the current HPSA scoring process and its effect on certain medically underserved communities.

Inclusion of other health care providers

Currently various types of primary care providers are funded through the NHSC scholarship and loan repayment programs. The committee recognizes that the intent of the NHSC program, as stated in statute, is to assure an adequate supply of primary care providers such as physicians, dentists, behavioral and mental health professionals, certified nurse midwives, certified nurse practitioners, and physicians assistants, and if needed by the Corps, other health professionals. The committee understands that these other practitioners provide first contact care for basic health services that are needed by most or all of the population. For the purposes of the Act, Section 338B National Health Service Corps Loan Repayment Program, the term "other health professionals" is intended to include optometrists, pharmacists, chiropractors, and physical therapists.

Frontier areas

The health care challenges facing rural America are magnified in the Nation's frontier. Frontier communities often do not have adequate access to health care providers. Their populations must travel for an excessive time or across a great distance to see a doctor, dentist, or counselor. Even when frontier communities have local access to health care, they are frequently underserved. Moreover, frontier communities may fail to be designated as HPSA because the population-to-provider ratio used can overestimate a frontier population's access to health care. There are two reasons for this problem. First, frontier communities are sparsely populated. Low population communities can exceed the 3000-to-1 threshold with a single health provider. Second, the population-to-provider ratio ignores the extra strain that geographic isolation imposes on health

care providers. For example, a frontier area with a population of 4,000 may be served by only a few healthcare providers. With the nearest hospital an hour long drive or more away, these few providers may need to work long hours every day of the week to provide critical emergency care in addition to basic health care.

The committee recommends that HRSA consider the challenges faced by frontier areas in the HPSA scoring process. The committee also encourages HRSA to consider incorporating other factors into the HPSA scoring process, such as the travel time and/or distance frontier residents have to travel to reach the nearest health care center. Consideration of these factors may more accurately reflect a frontier community's true access to health care.

Professional development

The Public Health Service Act is amended in two places to include an increased emphasis on professional development and training for Corps members. Section 333 amends the assignment of Health Professional Shortage Areas to include language indicating that the entity demonstrate a willingness to support or facilitate mentorship, professional development, and training opportunities for Corps members. Section 336, subsection d is amended to include a section on professional development and training.

More than 3,000 Health Professional Shortage Areas have been designated in our country, and approximately 56 million people live in communities without access to health care. The National Health Service Corps program was developed to help assign Federal personnel to these shortage areas. It was later expanded to provide scholarships to health professionals who then provided service to underserved communities. Currently, there are more than 4,000 health care professionals serving with the National Health Service Corps and providing care to communities that lack adequate access to primary care. However, there is still enormous unmet need in the program, with more sites that request health professionals than there are enrollees in the program.

Part of this shortage is due to the lack of funding for the program; part of this shortage is due to changes in the number of health professionals choosing careers in primary care. From 1995 to 2005, the number of medical school graduates entering family medicine training programs dropped by double digits.[19] In addition, there are shortages of faculty needed to train other primary care providers, like nurse practitioners. As a result, the National Health Service Corps is facing competition for an increasingly limited pool of health professionals.

While the National Health Service Corps provides scholarships and loan repayment opportunities, in this reauthorization, the committee sought to increase the incentives to help with recruitment and retention of primary care providers. The reauthorization contains language to expand the types of professional development opportunities available to enrollees, including expanding the professional and support networks among enrollees, and encouraging increased use of distance learning opportunities. In addition, the reauthorization requires entities seeking NHSC enrollees to demonstrate willingness to support professional development and train-

[19] Journal of the American Medical Association Sept 7, 2005; Vol 294, No 9.

ing opportunities. With this expansion, the committee believes that NHSC members will have added benefits that may help to increase recruitment and retention.

V. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 11, 2008.

Hon. EDWARD M. KENNEDY, *Chairman,*
Committee on Health, Education, Labor, and Pensions,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 901, the Health Care Safety Net Act of 2007.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lara Robillard.

Sincerely,

ROBERT A. SUNSHINE
(For Peter R. Orszag, Director).

Enclosure.

S. 901—Health Care Safety Net Act of 2007

Summary: S. 901 would amend the Public Health Service Act to authorize programs that provide funding for community health centers, the National Health Service Corps, and certain rural health programs administered by the Health Resources and Services Administration.

The bill would authorize the appropriation of $2.4 billion for 2008 and $15.1 billion over the 2008–2012 period. However, $2.2 billion has already been appropriated for those activities for 2008. Thus, S. 901 would authorize the appropriation of an additional $0.2 billion for fiscal year 2008 and $12.9 billion over the 2008–2012 period.

CBO estimates that implementing the bill would cost $94 million in 2008, $1.5 billion in 2009, and $12.5 billion over the 2008–2013 period, assuming the appropriation of the authorized amounts. S. 901 would not affect direct spending or revenues.

S. 901 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 901 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—					
	2008	2009	2010	2011	2012	2013
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law:						
Community Health Centers:						
Budget Authority	2,022	0	0	0	0	0
Estimated Outlays	2,035	989	231	0	0	0
National Health Service Corps:						
Budget Authority	123	0	0	0	0	0
Estimated Outlays	122	62	10	0	0	0

	By fiscal year, in millions of dollars—					
	2008	2009	2010	2011	2012	2013
Rural Health Outreach Grants:						
Budget Authority	48	0	0	0	0	0
Estimated Outlays	47	20	2	0	0	0
Total:						
Budget Authority	2,193	0	0	0	0	0
Estimated Outlays	2,204	1,071	243	0	0	0
Proposed Changes:						
Community Health Centers:						
Authorization Level	191	2,451	2,758	3,116	3,537	0
Estimated Outlays	90	1,383	2,505	2,883	3,266	1,579
National Health Service Corps:						
Authorization Level	8	143	156	170	186	0
Estimated Outlays	4	79	144	160	175	83
Rural Health Outreach Grants:						
Authorization Level	0	45	45	45	45	0
Estimated Outlays	0	24	43	44	44	20
Total Changes:						
Authorization Level	199	2,639	2,959	3,331	3,768	0
Estimated Outlays	94	1,486	2,692	3,087	3,485	1,682
Estimated Spending Under S. 901:						
Community Health Centers:						
Authorization Level	2,213	2,451	2,758	3,116	3,537	0
Estimated Outlays	2,125	2,372	2,736	2,883	3,266	1,579
National Health Service Corps:						
Authorization Level	131	143	156	170	186	0
Estimated Outlays	126	141	154	160	175	83
Rural Health Outreach Grants:						
Authorization Level	48	45	45	45	45	0
Estimated Outlays	47	44	45	44	44	20
Total Spending:						
Authorization Level	2,392	2,639	2,959	3,331	3,768	0
Estimated Outlays	2,298	2,557	2,935	3,087	3,485	1,682

Note: Components may not add to totals because of rounding.

Basis of estimate: S. 901 would authorize three programs that provide funding for health programs in rural and medically underserved areas. In total, the bill would authorize the appropriation of $2.4 billion for 2008 and $15.1 billion over the 2008–2012 period. The Omnibus Appropriations Act (Public Law 110–161) appropriated $2.2 billion in 2008 for those activities. Thus, S. 901 would authorize the appropriation of an additional $199 million for fiscal year 2008 and $12.9 billion over the 2008–2012 period.

Based on historical patterns of spending for those programs, and assuming the appropriation of the authorized amounts, CBO estimates that implementing the bill would cost $94 million in 2008, $1.5 billion in 2009, and $12.5 billion over the 2008–2013 period.

Community health centers are community-based and patient-directed organizations that serve populations with limited access to primary health care services. S. 901 would authorize the appropriation of $2.2 billion for 2008 (an increase of $191 million over the current appropriation), and $11.9 billion over the 2009–2012 period. Assuming the appropriation of the additional funds for 2008 in the spring, and the appropriation of the authorized amounts in subsequent years, CBO estimates that spending for the community health center program from the funds authorized by this bill would total $90 million in 2008 and $11.7 billion over the 2008–2013 period.

The National Health Service Corps operates loan repayment and scholarship programs for clinicians who provide primary care services in medically underserved areas. S. 901 would authorize the ap-

propriation of $132 million for 2008 (an increase of $8 million over the current appropriation), and $655 million over the 2009–2012 period. Assuming the appropriation of the additional funds for 2008 in the spring, and the appropriation of the authorized amounts in subsequent years, CBO estimates that spending for the National Health Service Corps program from the funds authorized by this bill would total $4 million in 2008 and $645 million over the 2008–2013 period.

The rural health care services outreach, network and quality improvement program provides grants for activities to increase access to primary health care services in rural areas; help rural health care providers develop community-based, integrated systems of care; and improve the quality of health care for certain chronic diseases. The bill would authorize the appropriation of $45 million a year for fiscal years 2008 through 2012. The amount authorized for 2008 is less than the $48 million appropriated for 2008. Therefore, the estimate assumes that enacting S. 901 would have no effect on funding for 2008. Assuming the appropriation of the amounts authorized for fiscal years 2009 through 2012, CBO estimates that spending for rural health outreach grants from the funds authorized by this bill would total $175 million over the 2008–2013 period.

Intergovernmental and private-sector impact: S. 901 contains no intergovernmental or private-sector mandates as defined in UMRA. Funds authorized in the bill would benefit local governments that participate in community and rural health programs.

Estimate prepared by: Federal Costs: Lara Robillard; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Patrick Bernhardt.

Estimate approved by: Keith J. Fontenot, Deputy Assistant Director for Health and Human Resources, Budget Analysis Division.

VI. Regulatory Impact Statement

The committee has determined that there is no legislative impact.

VII. Application of Law to the Legislative Branch

The committee has determined that there will be minimal increases in the regulatory burden imposed by this bill.

VIII. Section-by-Section Analysis

Section 1. Short title

Section 1 provides the short title of the bill, the "Health Care Safety Net Act of 2007."

Section 2. Community Health Centers Program of the Public Health Service Act

Section 2 part (a) amends section 330(r) of the Public Health Service Act to increase the authorization levels for the Health Centers Program for Fiscal Year 2008–2012.

Part (b) includes several studies relating to community health centers.

Subsection 1 includes definitions of the terms "community health center" and "medically underserved."

Subsection 2 describes a school based health center study to be conducted by the Comptroller General of the United States. No later than 2 years after the enactment of the act, the GAO shall study the economic costs and benefits of school based health centers and the impact on the health of students served by these centers. The study would analyze the impact of Federal funding on the operation of school based health centers, any cost savings to other Federal programs derived from providing services in these centers, the potential impact on the Federal budget and the health of students, and the impact on access to health care in rural or underserved areas.

Subsection 3 describes a health care quality study to be conducted by the Agency for Healthcare Research and Quality (AHRQ). This study would describe AHRQ's efforts to expand and accelerate quality improvement activities in community health centers, including Federal efforts towards improved healthcare quality, identification of effective models for quality improvement, and efforts to determine how effective quality improvement models may be adapted for implementation by CHCs with varying characteristics such as size, budget, staffing etc. This section also directs the Administrator of HRSA to establish a formal mechanism for the ongoing dissemination of agency initiatives, best practices, and other information that may assist health care quality improvement efforts.

Subsection 4 describes a study to be conducted by the GAO on an integrated health systems model for the delivery of health care services to medically underserved populations. This study, to be conducted at not more than 10 sites, would examine health care delivery models sponsored by public or nonprofit entities that integrate primary, specialty, and acute care and serve medically underserved populations in rural or urban areas. The report would evaluate the model's ability to expand access to primary and preventive services for medically underserved populations, improve care coordination and health care outcomes, while also assessing the challenges in providing care to medically underserved populations, and the advantages and disadvantages of such health care delivery models compared to other such models.

Section 3. National Health Service Corps

Section 3 part (a) amends section 331 through 338G of the Public Health Service Act to increase the authorization levels for the National Health Service Corps program for Fiscal Years 2008–2012.

Part (b) amends section 332(a)(1) of the Public Health Service Act to strike language that limited the automatic Health Professions Shortage Area designation for Community Health Centers and rural health programs to 6 years. The automatic HPSA designation will continue indefinitely.

Part (c) amends section 333(a)(1)(D)(ii) of the Public Health Service Act on the assignment of personnel to HPSAs to include a new requirement that a site seeking a NHSC assignee must demonstrate a willingness to support mentorship, professional development, and training opportunities for Corps members.

Part (d) amends subsection (d) of section 336 of the Public Health Service Act to include a new section on professional development and training. This new language requires the Secretary to assist Corps members in establishing and maintaining professional relationships and development opportunities. In providing this assistance, the Secretary shall focus on establishing relationships with hospitals, academic medical centers, health professions schools, area health education centers, health education and training centers, and border health education and training centers. The Secretary shall also assist Corps members in obtaining faculty appointments at health professions schools.

Section 4. Reauthorization of Rural Health Care Programs

Section 4 amends section 330A(j) of the Public Health Service Act by increasing the authorization level for rural health care programs to $45 million for fiscal years 2008 through 2012.

IX. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

SEC. 330. [254b] HEALTH CENTERS.

(a) DEFINITION OF HEALTH CENTER.—

(1) IN GENERAL.— * * *

* * * * * * *

(r) AUTHORIZATION OF APPROPRIATIONS.—

[(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated $1,340,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006.]

(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

(A) $2,213,020,000 for fiscal year 2008;

(B) $2,451,394,400 for fiscal year 2009;

(C) $2,757,818,700 for fiscal year 2010;

(D) $3,116,335,131 for fiscal year 2011; and

(E) $3,537,040,374 for fiscal year 2012.

* * * * * * *

SEC. 330A. [254c] RURAL HEALTH CARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, AND SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.

(a) PURPOSE.—* * *

* * * * * * *

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section [$40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.] *$45,000,000, for each of fiscal years 2008 through 2012.*

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SEC. 332. [254e] (a)(1) For purposes of this subpart the term "health professional shortage area" means (A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage, (B) a population group which the Secretary determines has such a shortage, or (C) a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage. All Federally qualified health centers and rural health clinics, as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)), that meet the requirements of section 334 shall be automatically designated as having such a shortage. [Not earlier than 6 years after such date of designation, and every 6 years thereafter, each such center or clinic shall demonstrate that the center or clinic meets the applicable requirements of the Federal regulations regarding the definition of a health professional shortage area for purposes of this section.] The Secretary shall not remove an area from the areas determined to be health professional shortage areas under subparagraph (A) of the preceding sentence until the Secretary has afforded interested persons and groups in such area an opportunity to provide data and information in support of the designation as a health professional shortage area or a population group described in subparagraph (B) of such sentence or a facility described in subparagraph (C) of such sentence, and has made a determination on the basis of the data and information submitted by such persons and groups and other data and information available to the Secretary.

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SEC. 333. [254f] (a)(1) * * *

(A) * * *

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(D) * * *

(I) * * *

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(IV) the area has made unsuccessful efforts to secure health manpower for the area; [and]

(V) there is a reasonable prospect of sound fiscal management, including efficient collection of fee-for-service, third-party, and other appropriate funds, by the entity with respect to Corps members assigned to such entity[.]*; and*

(VI) the entity demonstrates willingness to support or facilitate mentorship, professional development, and training opportunities for Corps members.

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SEC. 336. [254h–1] FACILITATION OF EFFECTIVE PROVISION OF CORPS SERVICES.

(a) CONSIDERATION OF INDIVIDUAL CHARACTERISTICS OF MEMBERS IN MAKING ASSIGNMENTS.—* * *

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[(d) ASSISTANCE IN ESTABLISHING LOCAL PROFESSIONAL RELATIONSHIPS.—The Secretary shall assist Corps members in establishing appropriate professional relationships between the Corps member involved and the health professions community of the geographic area with respect to which the member is assigned, including such relationships with hospitals, with health professions schools, with area health education centers under section 781, with health education and training centers under such section, and with border health education and training centers under such section. Such assistance shall include assistance in obtaining faculty appointments at health professions schools.]

(d) PROFESSIONAL DEVELOPMENT AND TRAINING.—

(1) IN GENERAL.—The Secretary shall assist Corps members in establishing and maintaining professional relationships and development opportunities, including by—

(A) establishing appropriate professional relationships between the Corps member involved and the health professions community of the geographic area with respect to which the member is assigned;

(B) establishing professional development, training, and mentorship linkages between the Corps member involved and the larger health professions community, including through distance learning, direct mentorship, and development and implementation of training modules designed to meet the educational needs of offsite Corps members;

(C) establishing professional networks among Corps members; or

(D) engaging in other professional development, mentorship, and training activities for Corps members, at the discretion of the Secretary.

(2) ASSISTANCE IN ESTABLISHING PROFESSIONAL RELATIONSHIPS.—In providing such assistance under paragraph (1), the Secretary shall focus on establishing relationships with hospitals, with academic medical centers and health professions schools, with area health education centers under section 751, with health education and training centers under section 752, and with border health education and training centers under such section 752. Such assistance shall include assistance in obtaining faculty appointments at health professions schools.

(3) SUPPLEMENT NOT SUPPLANT.—Such efforts under this subsection shall supplement, not supplant, non-government efforts by professional health provider societies to establish and maintain professional relationships and development opportunities.

SEC. 338. [254k] (a) For the purpose of carrying out this subpart, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years [2002 through 2006] *2008 through 2012.*

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SEC. 338H. [254q] AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this subpart, there are authorized to be [appropriated $146,250,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.] *appropriated—*

(1) for fiscal year 2008, $131,500,000;
(2) for fiscal year 2009, $143,335,000;
(3) for fiscal year 2010, $156,235,150;
(4) for fiscal year 2011, $170,296,310; and
(5) for fiscal year 2012, $185,622,980.

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Amend the title so as to read: A bill to amend the Public Health Service Act to reauthorize the Community Health Centers program, the National Health Service Corps, and rural health care programs.

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